General

Guideline Title

Communicable diseases. In: Guidelines for preventive activities in general practice, 8th edition.

Bibliographic Source(s)

Communicable diseases. In: Guidelines for preventive activities in general practice, 8th edition. East Melbourne (Australia): Royal Australian College of General Practitioners; 2012. p. 34-39.

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

The levels of evidence (I-IV, Practice Point) and grades of recommendations (A-D) are defined at the end of the "Major Recommendations" field.

Communicable Diseases

General practitioners (GPs) have an important role in the prevention and management of communicable diseases. This includes advice on prevention, immunisation, early detection and treatment.

Updates on communicable diseases and notification requirements are available from the Australian Department of Health and Ageing at www.health.gov.au/internet/main/publishing.nsf/Content/cda-surveil-nndss-casedefs-distype.htm.

GPs' laboratories and hospitals are required by law to notify particular infectious diseases to their local or state public health units (this law overrides all privacy regulations). A list of state-specific notifiable infectious diseases is also available from state health department websites. This role has become almost completely automated by pathology laboratories as a result of advances in information technology. The GP may still need to ensure notification has occurred on occasions where a clinical diagnosis is made, or where clinical information is required. Please note that varicella and zoster are notifiable diseases with or without the need for pathology testing.

Immunisation

Immunisation is recommended for all children and adults at particular ages, according to the *Australian Immunisation Handbook* (A). GPs should advocate immunisation and counter the common misunderstandings and anti-vaccine campaigns.

The National Immunisation Program Schedule (NIPS) lists the recommended funded vaccines. There may be other vaccines that are not funded but are recommended in the *Australian Immunisation Handbook*. There may be variability in vaccines recommended/funded, for example,

hepatitis A (hep A) vaccine.

Vaccination for Special High-risk Groups

Adults or children who develop asplenia, human immunodeficiency virus (HIV) infection or a haematological malignancy, or who receive a bone marrow or other transplant (following recovery), may not be fit for some vaccinations, or may require additional vaccinations, including the need for repeat vaccinations as described at the Immunise Australia Program Web site .

Please see the original guideline document for information regarding health inequity.

The National Immunisation Program Schedule

Sequence	Age	Vaccine
1	Birth*	• Hepatitis B (hep B)
2 1 1 1 1 1	6–8 weeks	• Hep B • Diphtheria, tetanus, acellular pertussis (DTpa) • *Haemophilus influenzae* type b (Hib) • Inactivated poliomyelitis (IPV) • 13-valent pneumococcal (13vPCV) • Rotavirus†
3 2 2 2 2 2	4 months	• Hep B • DTpa • Hib • IPV • 13vPCV • Rotavirus†
4 3 3 3 3 (3)	6 months	• Hep B • DTpa • Hib • IPV • 13vPCV • Rotavirus† (Rotateq only)
	6 months to <5 years	• Influenza (for all Aboriginal and Torres Strait Islander peoples) annually
5 4 1 1 4	12 months	• Hep B (fifth dose for those born <32 weeks or <2,000 g birthweight) • Hib • Measles, mumps and rubella (MMR) first dose • Meningococcal C (MenCCV) • 13vPCV booster for high-risk groups
1	12–18 months	• Hepatitis A (hep A) (for Aboriginal and Torres Strait Islander peoples in the Northern Territory, Queensland, South Australia and Western Australia only)
2	18 months‡	• MMR and varicella, or MMRV instead of separate varicella at 18 months and MMR at age 4 years

Sequence	Age	Vaccine (when available)
2	18–24 months	• Hep A (for Aboriginal and Torres Strait Islander peoples in the Northern Territory, Queensland, South Australia and Western Australia only)
4	24 months	• 13vPCV booster (for Aboriginal and Torres Strait Islander children)
4 4 2 1	4 years	• DTpa • IPV • MMR (to be superseded by combined MMRV at 18 months by 2016) • 23vPPV (only for high-risk groups)
1 & 2 1 1, 2 & 3	12–13 years	• Hep B (2 adult doses for those not vaccinated against hep B) • Varicella (catch up until all immunised) • Human papillomavirus (HPV) (3 doses over 6 months, for both sexes – catch-up 2013–15)
5	15 years	• dTPa is the adult/adolescent vaccine
	15–49 years	• Influenza (for all Aboriginal and Torres Strait Islander peoples) annually • 23vPPV (only at-risk Aboriginal and Torres Strait Islander peoples)
	50 years and over§	• Influenza (Aboriginal and Torres Strait Islander peoples) • 23vPPV (Aboriginal and Torres Strait Islander peoples)
	65 years and over	• Influenza • 23vPPV

*Hep B vaccine (dose 1 or 0) should be given to all infants within 24 hours of birth ideally, but at most within 7 days of birth. Infants whose mothers are hepatitis B surface antigen positive should be given hepatitis B immunoglobulin within 12 hours of birth.

†Rotavirus vaccines are contraindicated in infants with a history of intussusception (IS), or predisposing abnormality to IS, or severe combined immunodeficiency. Rotavirus vaccines are time limited and differ in number of doses and timing:

Dose 1 must be given before age 12 weeks (Rotateq) or 14 weeks (Rotarix) or not at all.
Dose 2 must be given before age 24 weeks (Rotarix) or before 28 weeks (Rotateq) or not at all.
Dose 3 ONLY for Rotateq must be given before age 32 weeks or not at all.

‡MMR dose 2, previously at age 4 years, and separate varicella at 18 months, is to be replaced by combined MMRV at 18 months and predicted to be available by July 2013.

§It is recommended that all people aged 50 years should be given DT. dTPa is preferred instead of DT to protect from pertussis. This is funded for parents and 'carers of infants' under age 6 months in some states. It can be given regardless of timing of previous DT.

Recommended Vaccines in the *Australian Immunisation Handbook* Not in the NIPS

Age	Vaccine
Soon after birth	Bacillus Calmette–Guérin (BCG) (for Aboriginal and Torres Strait Islander peoples in the Northern Territory, Queensland, and parts of Northern South Australia).

From 6 months	Annual influenza vaccination is recommended for any person aged ≥6 months where there is a wish to reduce the likelihood of becoming ill with influenza. Only Influvac or Vaxigrip influenza vaccines are suitable for use from the age of 6 months.
Under 14 years	Varicella: a second dose improves protection from varicella from 94% to 98%.
Parents and carers of infants under age 6 months	Diphtheria, tetanus, and pertussis (dTPa) is recommended to protect the infant from pertussis. To maximise the protection of infants, the options are to give before, immediately after, or in the third trimester of pregnancy. The dTPa vaccine can be given at any time after diphtheria, tetanus (DT) and dTPa may be given again 10 years after previous dTPa. Please refer to the *Australian Immunisation Handbook* for details.
50 years	dTPa is preferred to DT (This booster dose is recommended if no tetanus immunisation was received in the previous 10 years.)*
From 60 years	Zoster virus live vaccine (e.g., Zostavax) for prevention of shingles.
All healthcare workers	• Hep B (and hep A in some jurisdictions) • Annual influenza • dTPa • MMR (if not immune) • Varicella (if not immune)
Men who have sex with men	Hep B and hep A
Injecting drug users	Hep B and hep A

*It is recommended that all 50-year-olds should be given DT. dTPa is preferred instead of DT to protect from pertussis. This is funded for parents and 'carers of infants' under age 6 months in some states. It can be given regardless of timing of previous DT.

Immunisation Information Resources Include

- The *Australian Government Immunisation Handbook* is online at http://immunise.health.gov.au.
- The Australian Childhood Immunisation Register enquiry line is available on telephone 1800 653 809. This phone number can be used to obtain information on the vaccination history of individuals from birth to 7 years of age given since 1 January 1996.
- The National Centre for Immunisation Research & Surveillance is at www.ncirs.usyd.edu.au.

Notification of Adverse Events

The reporting of adverse events following vaccinations varies geographically. It is possible to report direct to the Therapeutic Goods Administration from anywhere in Australia by telephoning 1800 044 114, or visiting its website at www.tga.gov.au/hp/problem-medicine-reporting-reactions.htm.

Sexually Transmitted Infections (STIs)

STIs are frequently seen in general practice, especially chlamydia, which is typically asymptomatic. It is important to detect it early in order to minimise potential complications, such as infertility, and to prevent transmission to others. It may also be appropriate to screen for other STIs. The individual's age and sexual behaviour and community STI prevalence all influence the level of risk, and should influence the choice of STI screening tests.

Sexual Health Consultation

Many patients and doctors do not like discussing sexual histories even when the patient is requesting STI testing, or it is indicated. While taking a sexual history is an important part of the assessment and management of STIs, it should not be a barrier to offering STI testing. The patient may not

disclose the truth to avoid embarrassment (Pavlin et al., 2008).

A non-judgemental attitude and environment will maximise patient disclosures on sexual matters (Preswell & Barton, 2000). It is important to ask open questions and to avoid terms that make assumptions about sexual behaviour or orientation (e.g., by using the term 'partner'). Issues to cover include current sexual activity, gender and number of partners, contraception (including use of condoms), immunisation status and other risk factors for blood-borne viruses (such as injecting drug use, tattooing and piercing). Investigations should be explained, and patients should be counselled and asked for consent before ordering tests such as HIV or hepatitis C.

Contact tracing is an important part of the management of most STIs, and it is the responsibility of the diagnosing clinician to facilitate the process of notifying current and past partners. This may be by a direct approach from the patient or their treating health professional, or by using online partner notification services such as:

- www.letthemknow.org.au
- www.thedramadownunder.info/notify (for males with male partners)
- www.bettertoknow.org.au (for Aboriginal youth)

For more information and to determine 'how far back to trace' see the contact tracing manual at www.ashhna.org.au/documents/STIContact_tracing_toolMay2011.pdf.

In the case of a notifiable condition, the patient should be informed that case notification to public health authorities will occur. Notification should be made as prescribed by the department of health in your state or territory.

STIs: Identifying Risks

Who Is at Higher Risk of Infection and Complications?	What Should Be Done?	How Often?	References

High-risk Asymptomatic
• All sexually active young people aged 15 to 29 years, particularly if:
  • Under age 20 years
  • Aboriginal or Torres Strait Islander
  • Inconsistent or no condom usage
  • Recent change in sexual partner
	Urine or genital swab for chlamydia (II,A)	Every 12 months
		
		A good opportunity is at same time as Pap test or presentation for other reasons.
			Guy et al., "Genital chlamydia," 2011; Kong et al., 2011; Hayman, 2004; Low et al., 2007; Queensland Health, 2004; Heal et al., 2002; Scholes et al., 1996

	Consider other infections based on risk assessment such as gonorrhoea, hepatitis B (hep B), syphilis and human immunodeficiency virus (HIV).		
	Consider trichomonas in remote communities. (III)		Uddin et al., 2011

Asymptomatic Men Who Have Sex with Men
• Higher risk in those who:
  • Have unprotected anal sex
  • Have had >10 partners in past 6 months
  • Participate in group sex or use recreational drugs during sex
	Urine and rectal swab for chlamydia polymerase chain reaction (PCR)
	
	Throat and rectal swab for
		Every 12 months and 3 to 6 monthly in higher risk men	STIs in Gay Men Action Group (STIGMA), 2010; Whiley et al., 2008; Australasian Society for HIV Medicine (ASHM), 2008

Who Is at Higher Risk of Infection and Complications?	What Should Be Done?	How Often?	References
	gonorrhoea, PCR. (III,B) Serology for HIV, syphilis and hep A and B serology if not vaccinated or immune Also offer hep A and B vaccination. (III,B)		
Sexual Contacts from the Last 6 Months of Infected Women and Men For how far back to trace, see www.ashhna.org.au/documents/STIContact_tracing_toolMay2011.pdf .	Test and treat contacts presumptively. (II,A) Consider other infections based on risk assessment such as gonorrhoea, hep B (if not vaccinated), syphilis and HIV. (III,B)	If chlamydia infection found (and treated), repeating testing to check for reinfection after 3 to 12 months may be appropriate	Guy et al., "Re-testing for chlamydia," 2011; Whittington et al., 2001; Orr et al., 2001; Centers for Disease Control and Prevention (CDC), 2006
Low Risk Heterosexual Asymptomatic Requesting 'STI Check-up'	Urine PCR or genital swab for chlamydia, serology for hep B (if not vaccinated or immune), syphilis and HIV (III,B)		ASHM, 2008

Tests to Detect STIs

Test	Technique	Site	References

Nucleic acid amplification test (NAAT) most commonly by PCR	• Should be (20 mL) first void urine (passed at least 1 hour after last having urinated (i.e., not midstream). (I,B)
	• PCR endocervical or vaginal swab (patient can self-collect) also possible in females. (I,B)
	• This technique has also been validated for anal or throat swabs:
	  • Rectal swab should be inserted ~3 cm into anus and rotated (asymptomatic men who have sex with men can be taught to perform this test themselves, with the aid of a visual diagram [see the NSWSTI Web site]).
	  • Throat swab should sample the posterior pharyngeal wall and tonsillar crypts.
	• NAATs are highly sensitive and specific for chlamydia and gonorrhoea from all specimens. False positive gonorrhoea results can occur, especially if testing low-risk individuals. However, laboratories usually perform supplemental assays to confirm results for gonorrhea.
		Urine, endocervix or vagina	Cook et al., 2005; Orr et al., 2001; Watson et al., 2002; ASHM, 2008

Test	Technique	Site	References
Gonorrhoea microscopy, culture and sensitivity (MCS)	• Rectal swab should be inserted 3 cm into anus and rotated. • MCS is of use to guide treatment where resistance to antibiotics is a problem.		Ministry of Health, 2008

Definitions:

Levels of Evidence

Level	Explanation
I	Evidence obtained from a systematic review of level II studies
II	Evidence obtained from a randomised controlled trial (RCT)
III–1	Evidence obtained from a pseudo-randomised controlled trial (i.e., alternate allocation or some other method)
III–2	Evidence obtained from a comparative study with concurrent controls: • Non-randomised, experimental trial • Cohort study • Case–control study • Interrupted time series with a control group
III–3	Evidence obtained from a comparative study without concurrent controls: • Historical control study • Two or more single arm study • Interrupted time series without a parallel control group
IV	Case series with either post-test or pre-test/post-test outcomes
Practice Point	Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees

Grades of Recommendations

Grade	Explanation
A	Body of evidence can be trusted to guide practice
B	Body of evidence can be trusted to guide practice in most situations
C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
D	Body of evidence is weak and recommendation must be applied with caution

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

- Communicable diseases
  - Hepatitis A and B
  - Diphtheria
  - Tetanus
  - Pertussis
  - *Haemophilus influenzae* infection
  - Poliomyelitis
  - Pneumococcal infection
  - Rotavirus infection
  - Measles
  - Mumps
  - Rubella
  - Meningococcal infection
  - Varicella (chickenpox)
  - Herpes zoster (shingles)
  - Influenza
  - Bacillus Calmette–Guérin
- Sexually transmitted infections (STIs)
  - Chlamydia
  - Gonorrhoea
  - Hepatitis A, B, and C
  - Syphilis
  - Human immunodeficiency virus (HIV) infection
  - Human papillomavirus

Guideline Category

Prevention

Risk Assessment

Screening

Clinical Specialty

Family Practice

Infectious Diseases

Internal Medicine

Obstetrics and Gynecology

Pathology

Pediatrics

Preventive Medicine

Intended Users

Advanced Practice Nurses

Clinical Laboratory Personnel

Health Care Providers

Nurses

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

- To facilitate evidence-based preventive activities for communicable diseases in primary care
- To provide a comprehensive and concise set of recommendations for patients in general practice with additional information about tailoring risk and need
- To provide the evidence base for which primary healthcare resources can be used efficiently and effectively while providing a rational basis to ensure the best use of time and resources in general practice

Target Population

- General population in Australia from birth to age ≥65, including Aboriginal and Torres Strait Islander peoples (for immunisation)
- All individuals in Australia at risk for sexually transmitted infections (STIs) including:
    - All asymptomatic sexually active young people aged 15-29 years
    - Asymptomatic men with have sex with men
    - Sexual contacts from the last 6 months of infected women and men
    - Low risk heterosexual asymptomatic individuals requesting 'STI check-up'

Interventions and Practices Considered

1. Immunisation with the following vaccines
    - Hepatitis B (hep B)
    - Diphtheria, tetanus, acellular pertussis (DTpa [children], dTPa [adults/adolescents])
    - *Haemophilus influenzae* type b (Hib)
    - Inactivated poliomyelitis (IPV)
    - 13-valent pneumococcal (13vPCV)
    - Rotavirus
    - Measles, mumps, rubella (MMR)
    - Meningococcal C (MenCCV)
    - Hepatitis A (hep A)
    - Varicella
    - Influenza
    - Bacillus Calmette-Guérin (BCG)
    - Zoster virus live vaccine (Zostavax)
    - Human papillomavirus (HPV)
2. Sexual health history
3. Risk assessment for sexually transmitted infections (STIs)
4. STI screening and testing
    - Urine and genital or rectal swab for chlamydia
    - Throat and rectal swab for gonorrhoea polymerase chain reaction (PCR)
    - Serology for human immunodeficiency virus (HIV), syphilis, hepatitis A, and hepatitis B
    - Nucleic acid amplification test (NAAT) most commonly by PCR
    - Gonorrhoea microscopy, culture and sensitivity
5. Contact tracing and notification

Major Outcomes Considered

- Infection rate
- Transmission rate including perinatal transmission
- Complication rate
- Risk of sexually transmitted infections

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Sources of Recommendations

The recommendations in these guidelines are based on current, evidence-based guidelines for preventive activities. The Taskforce focused on those most relevant to Australian general practice. Usually this means that the recommendations are based on Australian guidelines such as those endorsed by the National Health and Medical Research Council (NHMRC).

In cases where these are not available or recent, other Australian sources have been used, such as guidelines from the Heart Foundation, Canadian or United States preventive guidelines, or the results of systematic reviews. References to support these recommendations are listed. However, particular references may relate to only part of the recommendation (e.g., only relating to one of the high-risk groups listed) and other references in the section may have been considered in formulating the overall recommendation.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Level	Explanation
I	Evidence obtained from a systematic review of level II studies
II	Evidence obtained from a randomised controlled trial (RCT)
III–1	Evidence obtained from a pseudo-randomised controlled trial (i.e., alternate allocation or some other method)
III–2	Evidence obtained from a comparative study with concurrent controls: • Non-randomised, experimental trial • Cohort study

Level	Explanation
	• Case–control study • Interrupted time series with a control group
III–3	Evidence obtained from a comparative study without concurrent controls: • Historical control study • Two or more single arm study • Interrupted time series without a parallel control group
IV	Case series with either post-test or pre-test/post-test outcomes
Practice Point	Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

These *Guidelines for preventive activities in general practice*, 8th edition, have been developed by a taskforce of general practitioners (GPs) and experts to ensure that the content is the most valuable and useful for GPs and their teams. The guidelines provide an easy, practical and succinct resource. The content broadly conforms to the highest evidence-based standards according to the principles underlying the Appraisal of Guidelines Research and Evaluation.

The dimensions addressed are:

- Scope and purpose
- Clarity of presentation
- Rigour of development
- Stakeholder involvement
- Applicability
- Editorial independence

The Red Book maintains developmental rigour, editorial independence, relevance and applicability to general practice.

Screening Principles

The World Health Organization (WHO) has produced guidelines for the effectiveness of screening programs. The Taskforce has kept these and the United Kingdom National Health Services' guidelines in mind in the development of recommendations about screening and preventive care.

Rating Scheme for the Strength of the Recommendations

Grades of Recommendations

Grade	Explanation
A	Body of evidence can be trusted to guide practice
B	Body of evidence can be trusted to guide practice in most situations
C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
D	Body of evidence is weak and recommendation must be applied with caution

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Peer Review

Description of Method of Guideline Validation

Not stated

Evidence Supporting the Recommendations

References Supporting the Recommendations

Australasian Society for HIV Medicine. HIV, viral hepatitis and STIs: a guide for primary care. Sydney: ASHM; 2008.

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Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for selected recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Reduced infection and complication rates

Potential Harms

- Adverse events following vaccinations
- False positive gonorrhoea results can occur, especially if testing low-risk individuals.

Contraindications

Contraindications

Rotavirus vaccines are contraindicated in infants with a history of intussusception (IS), or predisposing abnormality to IS, or severe combined immunodeficiency.

Qualifying Statements

Qualifying Statements

- The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. Nor is this publication exhaustive of the subject matter. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular circumstances when so doing. Compliance with any recommendations cannot of itself guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional and the premises from which the health professional operates.
- Whilst the text is directed to health professionals possessing appropriate qualifications and skills in ascertaining and discharging their professional (including legal) duties, it is not to be regarded as clinical advice and, in particular, is no substitute for a full examination and consideration of medical history in reaching a diagnosis and treatment based on accepted clinical practices.
- Accordingly, the Royal Australian College of General Practitioners and its employees and agents shall have no liability (including without limitation liability by reason of negligence) to any users of the information contained in this publication for any loss or damage (consequential or otherwise), cost or expense incurred or arising by reason of any person using or relying on the information contained in this publication and whether caused by reason of any error, negligent act, omission or misrepresentation in the information.
- These guidelines have not included detailed information on the management of risk factors or early disease (e.g., what medications to use in treating hypertension). Similarly, they have not made recommendations about tertiary prevention (preventing complications in those with established disease). Also, information about prevention of infectious diseases has been limited largely to immunisation and some sexually transmitted infections (STIs).

Implementation of the Guideline

Description of Implementation Strategy

For preventive care to be most effective, it needs to be planned, implemented and evaluated. Planning and engaging in preventive health is increasingly expected by patients. The Royal Australian College of General Practitioners (RACGP) thus provides the Red Book and *National guide to inform evidence-based guidelines*, and the Green Book (see the "Availability of Companion Documents" field) to assist in development of programs of implementation. The RACGP is planning to introduce a small set of voluntary clinical indicators to enable practices to monitor their preventive activities.

Implementation Tools

Chart Documentation/Checklists/Forms

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Communicable diseases. In: Guidelines for preventive activities in general practice, 8th edition. East Melbourne (Australia): Royal Australian College of General Practitioners; 2012. p. 34-39.

Adaptation

This guideline has been partially adapted from several Australian, Canadian, United Kingdom, and/or United States preventive guidelines.

Date Released

2012

Guideline Developer(s)

Royal Australian College of General Practitioners - Professional Association

Source(s) of Funding

Royal Australian College of General Practitioners

Guideline Committee

Red Book Taskforce

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the Royal Australian College of General Practitioners (RACGP) Web site .

Availability of Companion Documents

The following are available:

- Preventive activities over the lifecycle – adults. Preventive activities over the lifecycle – children. Electronic copies: Available in Portable Document Format (PDF) from the Royal Australian College of General Practitioners (RACGP) Web site .
- Putting prevention into practice (green book). East Melbourne (Australia): Royal Australian College of General Practitioners; 2006. 104 p. Electronic copies: Available in PDF from the RACGP Web site .
- National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people. East Melbourne (Australia): Royal Australian College of General Practitioners; 2012. 100 p. Electronic copies: Available in PDF from the RACGP Web site .

Patient Resources

None available

NGC Status

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